STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for a State Licensure Survey. This visit included the Investigation of Complaints IN00086981, IN00087366 and IN00087411. Complaints IN00086981, IN00087366 and IN00087411 - Substantiated. State deficiencies related to the allegations are cited at R241, R247 and R297. Survey dates: April 4, 5, 6, 7, and 8, 2011 Facility number: 006489 Provider number: 006489 AIM number: N/A Survey team: Penny Marlatt, RN, TC Diana Sidell, RN Janie Faulkner, RN (April 6 and 7, 2011) Census bed type: Residential: 39 Total: 39 Census payor type: Other: 39 Total: 39 Sample: 7 Supplemental sample: 2	R0000	Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	These state findings are cited in accordance with 410 IAC 16.2-5. Quality review 4/14/11 by Suzanne Williams, RN			
R0086	The licensee: (1) is responsible for compliance with all applicable laws; and (2) has full authority and responsibility for the: (A) organization; (B) management; (C) operation; and (D) control; of the licensed facility. The delegation of any authority by the licensee does not diminish the responsibilities of the licensee.			
	Based on interview and record review, the facility failed to ensure compliance with CLIA regulations which indicates a facility which conducts blood glucose testing must hold a valid CLIA waiver certificate. This deficient practice has the potential to affect all 10 residents identified as diabetics. The facility also failed to ensure licensed nurses held a valid Indiana licensure in order to practice as Indiana licensed nurse for one LPN employed at the facility. This deficient practice has the potential to adversely affect the care of all residents. Findings include: 1. During the initial entry process on 4-4-11 at 10:10 with the current Director,	R0086	The application for a CLIA waiver Certificate has been initiated on April 15, 2011, to ensure compliance with CLIA regulations. The facility shall ensure licensed nurses hold a valid Indiana licensure in order to practice as an Indiana licensed nurse. **Other residents having the potential to be affected and corrective actions:** This deficient practice has the potential to affect all 10 residents identified as diabetics. **Measures to ensure practice does not recur:** All new hires must provide a valid Indiana license or certificate before they work any shifts. **This corrective action will be monitored by:** The office manager shall verify each license and/or certificate on www.mylicense.in.gov/everificatio n prior to employment.	05/29/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	she indicated she was unsure if the facility had a CLIA waiver. On 4-5-11 at 9:27 a.m., she indicated she could not find such a CLIA waiver document. She indicated that according to her [administrator's] manual, the facility should have one because they conduct fingersticks for blood sugars. 2. During review of the employee files on 4-7-11, documentation indicated LPN #1 did not have a valid Indiana license to practice as a practical nurse. Documentation indicated she held a valid license as a licensed practical nurse (LPN) in the state of Ohio. Documentation of an unsigned application for an Indiana license was provided on 4-7-11 which was dated 4-5-11. In interview with the Director of Nursing (DON) on 4-7-11 at 3:30 p.m., she indicated she thought the nursing staff had 4 months in which to obtain the current state's licensure. Documentation provided by the facility on 4-7-11 indicated LPN #1 had worked in the facility in the capacity of an LPN during the time period 3-7-11 through 3-13-11 for 30.30 hours.			
R0117	(b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.			
	Based on record review and interview, the facility failed to ensure adherence to regulations regarding having at least one employee with CPR (cardiopulmonary resuscitation) and first aide training on site at all times. This deficient practice has the potential to adversely affect all residents. Findings include: Review of 33 employee records indicated only 3 current employees have both CPR and first aide training. Of the 3 employees, none were nursing staff. The 3 current employees with both CPR and first aide training, 2 were dietary staff (Dietary Staff #9 and Dietary Staff#10)	R0117	As a means to ensure ongoing compliance, the State Ruleaddressing CPR and First Aid Certification has been reviewed with the administrative staff ofthe facility to ensureunderstanding of said rule. Corrective action for residents affected: This deficient practice has the potential to adversely affect all residents. All employee files are being audited.Employees who do not have a valid First Aid Certificate and a valid CPR Certificate will attend the First Aid and CPR Training Classes conducted by The American Heart Association on April 26th and 27th, 2011.Other residents having the potential to be affected and corrective actions: This deficient practice has the potential to adversely affect all	05/29/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and 1 was housekeeping staff (Housekeeper #8). In interview with the Director of Nursing on 4-8-11 at 3:35 p.m., she indicated the facility thought the licensure and training of the [licensed] nurses would cover the requirements for first aide and CPR.		residents. All employee files are being audited. Employees who do not have a valid First Aid Certificate and a valid CPR Certificate will attend the First Aid and CPR Training Classes conducted by the American Heart Association on April 26th and 27th, 2011.Measures to ensure practice does not recur: Personnel shall be assigned only those duties for which they are trained and oriented to perform. Employee duties shall conform to written facility job descriptions.This corrective action will be monitored by: The Resident Health and Services Director and facility Administrator shall meet on a monthly basis to review all employees and verify compliance with CPR and First Aid Certification as required by the Residential Rule. The Office Manager will be responsible to monitor for certification of employees upon hire and report certification needs to Resident Health and Services Director and the facility Administrator.	
R0121	(f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.			
	Based on record review and interview, the facility failed to ensure 3 of 5 employees had timely Mantoux (TB) testing and 1 of 5 employees had health screenings (physical examinations) conducted prior to employment. This deficient practice has the potential to adversely affect all residents. (Site Director, Dietary Staff #6 and CNA #7) Findings include:	R0121	All employee files are beingaudited and employees who didnot have a negative Mantoux within the past year will receive the step 1 and step 2 Mantoux testing conducted in adherence with the State Rule. As a means to ensure on going compliance, the State Rule addressing Mantoux testing has been reviewed with the administrative staff of the facility to ensureunderstanding of compliance withthe State Rule.Measures to ensure practice	05/29/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	In review of 5 employees employed within the last 120 days, 3 of 5 employees did not have Mantoux testing conducted within the month prior to employment. (Site Director, Dietary Staff #6, and CNA #7) This review also indicated 1 of 5 employees did not have a health screening in the month prior to employment (Site Director #5). In interview with the Site Director on 4-7-11 at 4:00 p.m., she indicated she was not required to have a physical for her position. In interview with the Director of Nursing on 4-7-11 at 4:22 p.m., she indicated she had not found all of the employee TB tests, but would continue to look for the test results.		does not recur: The Office Manager will report the employee mantoux testing needs to the Resident Health Services Director in order to maintain, monitor and coordinate appropriate testing of employees at the time of employment or within 1 month and at least annually thereafter. This corrective action will be monitored by: The Resident Health and Services Director and the facility Administrator willmeet on a monthly basis to review all employees to verifycompliance with mantoux testing as required by the residential rule.	
R0123	(h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on interview and record review, the facility failed to ensure current Indiana licensure for 1 Licensed Practical Nurse (LPN). The deficient practice has the potential to adversely affect the care of all residents. (LPN #1) Findings include: During review of the employee files on 4-7-11, documentation indicated LPN #1 did not have a valid Indiana license to practice as an LPN. Documentation indicated she held a valid license as an LPN in the state of Ohio. Documentation of an unsigned application for an Indiana nursing licensure was provided on 4-7-11 which was dated 4-5-11. In interview with the Director of Nursing (DON) on 4-7-11 at 3:30 p.m., she indicated she thought the nursing staff had 4 months in which to obtain the current state's licensure. Documentation provided by the facility on 4-7-11 indicated LPN #1 had worked in the capacity of an LPN in the facility during the time period 3-7-11 through 3-13-11 for 30.30 hours.	R0123	The facility shall maintain current and accurate personnel recordsfor all employees. Personnel records shall include the name and address of the employee,Social Security number, date ofbeginning employment, past employment, experience, and education, professional licensure or registration number or dining assistant certificate or letter of completion, position in the facility and job description, documentation of orientation to the facility, including residents' rights, signed acknowledgement of orientation to residents' rights, performance evaluations in accordance with facility policy, date and reason for separation. Corrective action for residents affected:The deficient practice has thepotential to adversely affect the care of all residents. The facility shall ensure current Indiana licensure, prior to employment. Other residents having the potential to be affected and corrective actions:The deficient practice has thepotential to adversely affect the care of all residents. The facility shall ensure current Indiana licensure, prior to employment.	05/29/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0217	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on observation, interview and record review, the facility failed to identify and document the services to be provided for 2 of 7 residents sampled regarding conducting hourly or every 2 hour checks for well being; failed to identify and document the services for 1 of 7 sampled residents requiring Level 3 care; and failed to follow the service plan	R0217	The facility has identified anddocumented services provided appropriate to the scope, frequency, need and preference of each resident.Corrective action for residents affected:Residents #4, #38 and #A:Unable to correct the clinicalrecord. Based on clinical record review, the facility has identified and documented	05/29/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	for 1 of 2 supplemental sampled residents who had been deemed unable to self-administer medications who was found to have unlabeled, non-physician ordered medications unsecured in their room. (Residents #4, #38 and #A) Findings include: 1. Resident #38's clinical record was reviewed 4-4-11 at 11:45 a.m. Her diagnoses included, but were not limited to, uncontrolled diabetes mellitus type 2, congestive heart failure and coronary artery disease. Review of the nursing notes indicated multiple documentation between 3-6-11 and 3-29-11 of the resident being checked on an hourly to every 2 hour basis. Documentation on 3-29-11 indicated discontinuation of "safety checks." Additional documentation on a "Safety Checks Form" which began on 3-6-11 and continued through 3-29-11 indicated the facility staff were to conduct these checks and in what time frame, such as hourly or every 2 hours. Review of Resident #38's Service Plan, dated 3-22-11 did not indicate identification of the reason for the need for safety checks nor the frequency for the safety checks to be conducted. 2. Resident #4's room was toured on		services provided to each resident on their individual service plans.Other residents having the potential to be affected and corrective actions:All residents have the potential tobe affected by this deficient practice. Based on clinical record review, the facility has identified and documented services provided to each resident on their individual service plans. Measures to ensure practice does not recur:The Resident Services Director or designee will review requireddocumentation and evaluations to accurately identify services provided. On April 27, 2011 allnursing staff was inserviced on Resident Service Planning. This corrective action will be monitored by:The Director of Health Servicesor designee will be responsiblefor completing a clinical record audit of all residents weekly for 4 weeks, then every other week for8 weeks, then monthly for 3 months. Results will be reported to the QA team for review and further corrective actions as deemed necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	4-6-11 at 2:45 p.m. with the Maintenance Director and Site Director during the environmental tour. During this tour, 3 bottles of over-the counter medications, labeled as Tylenol, Pepto Bismol and MegaRed, were observed on the kitchen counter near the kitchen sink. These bottles were observed to have only the manufacturer's label on them. In review of her clinical record on 4-6-11 at 3:20 p.m., a "Medication Assessment" form, dated 10-21-10, indicated the resident was deemed unable to safely self-administer any of her medications due to "short term memory loss and res (resident) can not correctly state what meds (medications) are for or times to take them." Review of the recapitulation orders for April 2011 did not include these medications as being ordered by the physician. 3. Resident #A's record was reviewed on 4/4/11 at 11:24 a.m. The record indicated Resident #A was admitted with diagnoses that included, but were not limited to, diabetes, high blood pressure, blood clot in leg, dementia, and congestive heart failure. During an interview on 4/4/11 at 10:30 a.m., CNA #2 indicated resident #A was on hourly checks due to being a fall risk,		The facility has identified anddocumented services provided appropriate to the scope, frequency, need and preference of each resident.Corrective action for residents affected:Residents #4, #38 and #A:Unable to correct the clinicalrecord. Based on clinical record review, the facility has identified and documented services provided to each resident on their individual service	05/29/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	used a wheel chair and could walk with assistance. A "LEVEL OF CARE DETERMINATION" dated 2/11/11 indicated Resident #A's functional assessment determined the resident to be a Level 3, which requires the highest level of assistance for a resident in assisted living. Review of the service plan failed to include the services for the hourly checks or the assisted living level 3 needs.		plans.Other residents having the potential to be affected and corrective actions:All residents have the potential tobe affected by this deficient practice. Based on clinical record review, the facility has identified and documented services provided to each resident on their individual service plans. Measures to ensure practice does not recur:The Resident Services Director or designee will review requireddocumentation and evaluations to accurately identify services provided. On April 27, 2011 allnursing staff was inserviced on Resident Service Planning. This corrective action will be monitored by:The Director of Health Servicesor designee will be responsiblefor completing a clinical record audit of all residents weekly for 4 weeks, then every other week for8 weeks, then monthly for 3 months. Results will be reported to the QA team for review and further corrective actions as deemed necessary.	
R0241	(e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review, observation and interview, the facility failed to administer medications as ordered by the physician in	R0241	Administration of medications and the provision of residential nursing care shall be as R 241 ordered by the resident's	05/29/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	that 4 residents had missed doses of medications (Residents #A, C, D, and 34), and 1 resident had unprescribed medications that were unlabeled and unsecured (Resident #4). This affected 3 of 7 residents reviewed for medication administration in a sample of 7 and 2 of 2 residents in a supplemental sample of 2. Findings include: A policy and procedure for "MEDICATION ERROR", with a revised date of February 2006, was provided by the Director of Health Services on 4/8/11 at 1:05 p.m. The policy included, but was not limited to: "...ALL medication errors that occur for residents receiving medication management services from the facility are required to be recorded. Medication management includes: medication set-up, reminders, assistance with self-administration (ex. cuing) and administration by licensed staff. A medication error includes: wrong medication, wrong dosage, wrong time...wrong route, missed medication. The medication Error Report form must be completed each time an error is discovered. ALL medications involved in the incident must be listed on the second page of the report form...All other medication errors shall be recorded on the Medication Error report and kept on file		physician.Corrective action for residents affected: Residents #A, C, D, and34: Unable to correct the clinical record. The facility shall administer medications as ordered by the physician.Other residents having the potential to be affected and corrective actions:All residents, to which, thefacility administers medications, have the potential to be affected by this deficient practice. Policies and procedures relative to Medication Management are in place to ensure professional standards of medication administration. On April 27, 2011all staff qualified to administermedications were inserviced on Medication Management. Measures to ensure practice does not recur:Policies and procedures relativeto Medication Management are in place to ensure professional standards of medication administration. On April 27, 2011 all staff qualified to administer medications were inserviced on Medication Management.This corrective action will be monitored by:The Director of Health Servicesor designee will be responsible for completing a clinical record audit of all residents weekly for 4 weeks, then every other week for8 weeks, then monthly for 3months. Results will be reported to the QA team for review and further corrective actions as deemed necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	in the Administrator's office for ISDOH review...." 1. Resident #A's record was reviewed on 4/4/11 at 11:24 a.m. The record indicated Resident #A was admitted with diagnoses that included, but were not limited to, diabetes, high blood pressure, depression, blood clot in leg, dementia, and congestive heart failure. Physician's orders for medications for March 2011, indicated orders for the following medications: - Acetaminophen 650 mg (milligrams) take 1 tablet every morning (for pain) - Humulin N 100 units/ml (milliliter) vial 42 units SQ (subcutaneous) every morning before or at breakfast (for diabetes) - Glimepiride 4 mg table, take 2 tablets daily (for diabetes) - Lisinopril 20 mg tablet, one tablet daily (for blood pressure) - Citalopram 10 mg tablet, take 1 daily (for depression) - Prednisone 5 mg, take 1 tablet daily by mouth daily (for cerebellar infarct) - Diltiazem 240 mg, take 1 capsule by mouth daily (for high blood pressure) - Warfarin sodium 4.5 mg every day (One 2 mg tablet and one 2.5 mg tablet) (for blood clot in leg) - Donepezil 5 mg by mouth daily (for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dementia) - Furosemide 80 mg by mouth two times a day (for high blood pressure and edema) - Tylenol PM extra strength caplet, 2 caplets at bedtime (for pain/sleep) Medication administration records (MARs) for March 2011 indicated the following medications had been initialed and then the initials circled to indicate the medication had not been give on March 5: - Warfarin sodium, both the 2 mg and the 2.5 mg tablets - Aricept 5 mg - Furosemide 80 mg - Tylenol PM 2 tablets The explanation on the back of the MARs indicated: "3/16/11 5 & 8 pm pills [not] taken 3/5/11 laying on counter this am." 2. Resident #C's record was reviewed on 4/6/11 at 11:25 a.m. The record indicated resident #C was admitted with diagnoses that included, but were not limited to, pacemaker, osteoarthritis, high blood fats, constipation, congestive heart failure, hypothyroidism, high blood pressure, chronic obstructive pulmonary disease (COPD), and back pain. Physician's orders for medications for February 2011, indicated orders for the following medications:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- Prednisone 5 mg 1 each morning (for COPD) - Levothyroxine 88 mcg (micrograms) 1 tablet daily (for hypothyroidism) - Docusate sodium 100 mg 1 tablet daily (for constipation) - Amiodarone 200 mg 2 tablet daily (for pacemaker) - Lisinopril 5 mg 1 tablet daily (for high blood pressure) - Metoprolol 25 mg 1 tablet 2 times a day (for congestive heart failure) - Calcium + D 600 mg 1 tablet 2 times a day (for osteoarthritis) - Furosemide 40 mg 1 tablet 2 times a day (for congestive heart failure) - Crestor 5 mg 1 tablet once a day at bedtime (for high blood fats) - Fentanyl 25 mcg/hour patch, apply one patch to skin every 72 hours (for pain) MARs for February 2011 indicated the following medications had been initialed and the initials circled which indicated the medication had not been given: - February 9 and 28: Crestor, with the explanation "med [not] available" on the back of the MAR. - February 21 and 22 at 8:00 a.m. and February 21 at 4:00 p.m.: Furosemide, with the explanation "[not] available" on the back of the MAR. MARs for March 2011 indicated the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	following medications had been initialed as not given: - February 2, 3, 6, and 10: Crestor, with the explanation on the back of the MAR of "med [not] available". On March 4, the Fentanyl 25 mcg/hr patch was due to be re-applied, and the box for that day was crossed out; the Fentanyl patch was initialed as applied on March 5th. The explanation on the back of the MAR indicated: "3/3/11 Fentanyl patch - patch was put on 3/5/11 8A patch signed out on 4th but not put on laying on counter." During an interview on 4/7/11 at 10:30 a.m. the Director of Health Services indicated a medication discrepancy report should have been written for the Fentanyl patch not being changed when due. 3. Resident #D's record was reviewed on 4/5/11 at 2:05 p.m. The record indicated Resident #D was admitted with diagnoses that included, but were not limited to, peripheral vascular disease, depression, Alzheimer's disease, high blood pressure, renal disease, vitamin B-12 deficiency, constipation, and insomnia. Physician's orders for medications for February 2011, indicated orders for the following medications:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- Temazepam 30 mg 1 capsule at bedtime (for insomnia) - Aspirin 81 mg, 1 tablet daily (for high blood pressure) - Hydrochlorothiazide 25 mg, 1/2 tablet daily (for high blood pressure) - Vitamin B-12 1,000 mcg tablet daily (for B-12 deficiency) - Paroxetine 20 mg daily (for depression) MARs for February 2011 indicated the following medications had been initialed and the initials circled which indicated the medication had not been given: - February 16: Temazepam, with the explanation on the back of the MAR "[not] available". - February 20: Aspirin, with the explanation on the back of the MAR "[not] available". - February 17 and 21: Vitamin B-12, with the explanation on the back of the MAR "[not] available". - February 19, 20, 21: Paroxetine, with the explanation on the back of the MAR "[not] available". 4. Resident #34's record was reviewed on 4/7/11 at 10:45 a.m. The record indicated Resident #34 was admitted with diagnoses that included, but were not limited to, high blood pressure, gastroesophageal reflux disease, high cholesterol, pulmonary high blood			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	pressure, depression, arthritis, macular degeneration, angina, and atrial fibrillation. Physician's orders for medications for March 2011, indicated orders for the following medications: - Ferrous sulfate 325 mg, 1 tab every day (anemia) - Klor-con 10 millequivalents, 1 tab twice a day - Alendronate sodium 40 mg, 1 tab every day - Diltiazem 24 hr ER, 150 mg, 1 capsule every day - Fexofenadine HCL 180 mg, 1 every day - Alprazolam 0.5 mg, 1 tab at bedtime - Paroxetine 20 mg, 1 tab every day - Furosemide 40 mg, 1 tab twice a day - Simvastatin 40 mg, 1 tab at bedtime (high cholesterol) - Fosamax 70 mg, 1 tab every Saturday (osteoporosis) - Omeprazole 20 mg, 1 tab daily (GERD) - Hydrocodone/apap 10/325, 1 tab four times a day (pain) MARs for February 2011 indicated the following medications had been initialed and the initials circled which indicated the medication had not been given: - March 24, 25, and 28: Alprazolam 0.5 mg, with the explanation on the back of the MAR - "[not] available" for the 3/24			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dose. The 3/25 dose had no explanation why it had not been given. A medication discrepancy report dated 3/29/11 indicated the Alprazolam dose for 3/28/11 had been omitted. 5. Resident #4's clinical record was reviewed on 4-6-11 at 3:20 p.m. Her diagnoses included, but were not limited to atrial fibrillation (irregular heartbeat), fatigue, macular degeneration (vision problems), and arthritis. Resident #4's room was toured on 4-6-11 at 2:45 p.m. with the Maintenance Director and Site Director during the environmental tour. During this tour, 3 bottles of over-the counter medications, labeled as Tylenol, Pepto Bismol and MegaRed, were observed on the kitchen counter near the kitchen sink. Review of the current recapitulation orders for April 2011 did not indicate Resident #4 was physician-ordered to receive Tylenol, Pepto-Bismol or MegaRed (an herbal supplement.) Review of a document entitled, "Medication Assessment," which was signed and dated on 10-21-10 by the resident and facility staff. This assessment indicated the resident had been deemed unable to self-administer her medications due to short term memory		Administration of medications and the provision of residential nursing care shall be as R 241 ordered by the resident's physician.Corrective action for residents affected: Residents #A, C, D, and34: Unable to correct the clinical record. The facility shall administer medications as ordered by the physician.Other residents having the potential to be affected and corrective actions:All residents, to which, thefacility administers medications, have the potential to be affected by this deficient practice. Policies and procedures relative to Medication Management are in place to ensure professional standards of medication administration. On April 27, 2011all staff qualified to administermedications were inserviced on Medication Management. Measures to ensure practice does not recur:Policies and procedures relativeto Medication Management are in place to ensure professional standards of medication administration. On April 27, 2011 all staff qualified to administer medications were inserviced on Medication	05/29/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	loss and inability to identify what the medications are for and when she should take her medications. In an interview with the Director of Nursing on 4-6-11 at 3:20 p.m., she indicated the facility had already removed the medications from the resident's room and contacted the resident's physician in order to get physician approval for these medications to be administered to her. This State Residential Rule finding relates to complaints IN00086981, IN00087366, and IN00087411.		Management.This corrective action will be monitored by:The Director of Health Servicesor designee will be responsible for completing a clinical record audit of all residents weekly for 4 weeks, then every other week for8 weeks, then monthly for 3months. Results will be reported to the QA team for review and further corrective actions as deemed necessary.	
R0247	(7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on record review and interview, the facility failed to ensure errors in medication administration were documented in the resident's record for 3 of 7 residents in a sample of 7 and 1 of 2 residents in a supplemental sample of 2. (Residents #A, C, D, and 34) Findings include: A policy and procedure for "MEDICATION ERROR", with a revised	R0247	Any error in medication administration shall be noted inthe resident ' s chart. The physician shall be notified immediately of any error inmedication administration whenthere are any actual or potential detrimental effects to the resident. The facility shall ensure errors in medication administration are documented in the resident's record.Corrective action for residents affected:Res A, C, D and 34- Unable to correct the clinical record.Medications	05/29/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	date of February 2006, was provided by the Director of Health Services on 4/8/11 at 1:05 p.m. The policy included, but was not limited to: "The facility will follow the guidelines for medication assistance established by the State of Indiana...ALL medication errors that occur for residents receiving medication management services from the facility are required to be recorded. Medication management includes: medication set-up, reminders, assistance with self-administration (ex. cuing) and administration by licensed staff. A medication error includes: wrong medication, wrong dosage, wrong time...wrong route, missed medication. The medication Error Report form must be completed each time an error is discovered. ALL medications involved in the incident must be listed on the second page of the report form...All other medication errors shall be recorded on the Medication Error report and kept on file in the Administrator's office for ISDOH review...." 1. Resident #A's record was reviewed on 4/4/11 at 11:24 a.m. The record indicated Resident #A was admitted with diagnoses that included, but were not limited to, diabetes, high blood pressure, depression, blood clot in leg, dementia, and congestive heart failure.		are administered according to physician order. Other residents having the potential to be affected and corrective actions:All residents, to which, thefacility administers medications, have the potential to be affected by this deficient practice. Policies and procedures relative to Medication Management are in place to ensure professional standards of medication administration. On April 27, 2011 all staff qualified to administer medications were inserviced on Medication Management.This corrective action will be monitored by:The Director of Health Services or designee will be responsible for completing a clinical recordaudit of all residents weekly for 4 weeks, then every other week for8 weeks, then monthly for 3 months. Results will be reported to the QA team for review and further corrective actions as deemed necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Physician's orders for medications for March 2011, indicated orders for the following medications: - Acetaminophen 650 mg (milligrams) take 1 tablet every morning (for pain) - Humulin N 100 units/ml (milliliter) vial 42 units SQ (subcutaneous) every morning before or at breakfast (for diabetes) - Glimepiride 4 mg table, take 2 tablets daily (for diabetes) - Lisinopril 20 mg tablet, one tablet daily (for blood pressure) - Citalopram 10 mg tablet, take 1 daily (for depression) - Prednisone 5 mg, take 1 tablet daily by mouth daily (for cerebellar infarct) - Diltiazem 240 mg, take 1 capsule by mouth daily (for high blood pressure) - Warfarin sodium 4.5 mg every day (One 2 mg tablet and one 2.5 mg tablet) (for blood clot in leg) - Donepezil 5 mg by mouth daily (for dementia) - Furosemide 80 mg by mouth two times a day (for high blood pressure and edema) - Tylenol PM extra strength caplet, 2 caplets at bedtime (for pain/sleep) Medication administration records (MARs) for March 2011 indicated the following medications had been initialed and then the initials circled to indicate the medication had not been give on March 5:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- Warfarin sodium, both the 2 mg and the 2.5 mg tablets - Aricept 5 mg - Furosemide 80 mg - Tylenol PM 2 tablets The explanation on the back of the MARs indicated: "3/16/11 5 & 8 pm pills [not] taken 3/5/11 laying on counter this am." No documentation of the medication error was found in Resident #A's record. 2. Resident #C's record was reviewed on 4/6/11 at 11:25 a.m. The record indicated resident #C was admitted with diagnoses that included, but were not limited to, pacemaker, osteoarthritis, high blood fats, constipation, congestive heart failure, hypothyroidism, high blood pressure, chronic obstructive pulmonary disease (COPD), and back pain. Physician's orders for medications for February 2011, indicated orders for the following medications: - Prednisone 5 mg 1 each morning (for COPD) - Levothyroxine 88 mcg (micrograms) 1 tablet daily (for hypothyroidism) - Docusate sodium 100 mg 1 tablet daily (for constipation) - Amiodarone 200 mg 2 tablet daily (for pacemaker)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- Lisinopril 5 mg 1 tablet daily (for high blood pressure) - Metoprolol 25 mg 1 tablet 2 times a day (for congestive heart failure) - Calcium + D 600 mg 1 tablet 2 times a day (for osteoarthritis) - Furosemide 40 mg 1 tablet 2 times a day (for congestive heart failure) - Crestor 5 mg 1 tablet once a day at bedtime (for high blood fats) - Fentanyl 25 mcg/hour patch, apply one patch to skin every 72 hours (for pain) MARs for February 2011 indicated the following medications had been initialed and the initials circled which indicated the medication had not been given: - February 9 and 28: Crestor, with the explanation "med [not] available" on the back of the MAR. - February 21 and 22 at 8:00 a.m. and February 21 at 4:00 p.m.: Furosemide, with the explanation "[not] available" on the back of the MAR. MARs for March 2011 indicated the following medications had been initialed as not given: - February 2, 3, 6, and 10: Crestor, with the explanation on the back of the MAR of "med [not] available". On March 4, the Fentanyl 25 mcg/hr patch was due to be re-applied, and the box for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	that day was crossed out; the Fentanyl patch was initialed as applied on March 5th. The explanation on the back of the MAR indicated: "3/3/11 Fentanyl patch - patch was put on 3/5/11 8A patch signed out on 4th but not put on laying on counter." During an interview on 4/7/11 at 10:30 a.m. the Director of Health Services indicated a medication discrepancy report should have been written for the Fentanyl patch not being changed when due. No documentation of the medication error was found in Resident #C's record. 3. Resident #D's record was reviewed on 4/5/11 at 2:05 p.m. The record indicated Resident #D was admitted with diagnoses that included, but were not limited to, peripheral vascular disease, depression, Alzheimer's disease, high blood pressure, renal disease, vitamin B-12 deficiency, constipation, and insomnia. Physician's orders for medications for February 2011, indicated orders for the following medications: - Temazepam 30 mg 1 capsule at bedtime (for insomnia) - Aspirin 81 mg, 1 tablet daily (for high blood pressure) - Hydrochlorothiazide 25 mg, 1/2 tablet			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	daily (for high blood pressure) - Vitamin B-12 1,000 mcg tablet daily (for B-12 deficiency) - Paroxetine 20 mg daily (for depression) MARs for February 2011 indicated the following medications had been initialed and the initials circled which indicated the medication had not been given: - February 16: Temazepam, with the explanation on the back of the MAR "[not] available". - February 20: Aspirin, with the explanation on the back of the MAR "[not] available". - February 17 and 21: Vitamin B-12, with the explanation on the back of the MAR "[not] available". - February 19, 20, 21: Paroxetine, with the explanation on the back of the MAR "[not] available". During an interview on 4/8/11 at 11:54 a.m., the Director of Health Services indicated if a medication was not given due to being unavailable, it is considered a medication error. No documentation of the medication error was found in Resident D's record. 4. Resident #34's record was reviewed on 4/7/11 at 10:45 a.m. The record indicated Resident #34 was admitted with			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	diagnoses that included, but were not limited to, high blood pressure, gastroesophageal reflux disease, high cholesterol, pulmonary high blood pressure, depression, arthritis, macular degeneration, angina, and atrial fibrillation. Physician's orders for medications for March 2011, indicated orders for the following medications: - Ferrous sulfate 325 mg, 1 tab every day (anemia) - Klor-con 10 millequivalents, 1 tab twice a day - Alendronate sodium 40 mg, 1 tab every day - Diltiazem 24 hr ER, 150 mg, 1 capsule every day - Fexofenadine HCL 180 mg, 1 every day - Alprazolam 0.5 mg, 1 tab at bedtime - Paroxetine 20 mg, 1 tab every day - Furosemide 40 mg, 1 tab twice a day - Simvastatin 40 mg, 1 tab at bedtime (high cholesterol) - Fosamax 70 mg, 1 tab every Saturday (osteoporosis) - Omeprazole 20 mg, 1 tab daily (GERD) - Hydrocodone/apap 10/325, 1 tab four times a day (pain) MARs for February 2011 indicated the following medications had been initialed and the initials circled which indicated the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medication had not been given: - March 24, 25, and 28: Alprazolam 0.5 mg, with the explanation on the back of the MAR - "[not] available" for the 3/24 dose. The 3/25 dose had no explanation why it had not been given. A medication discrepancy report dated 3/29/11 indicated the Alprazolam dose for 3/28/11 had been omitted. No documentation of the medication error was found in Resident #34's record. This State Residential Rule finding relates to complaints IN00086981, IN00087366, and IN00087411.			
R0297	(c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on record review and interview, the facility failed to ensure residents were provided with prescribed medications in that multiple doses of routinely given medications were not available. This affected 2 of 7 residents reviewed in a sample of 7 (Residents #C and D) and 1 of 2 residents reviewed in a supplemental	R0297	If the facility controls, handles, and administers medications for aresident, the facility shall arrange services with a compliance packaging pharmacy to ensurethat pharmaceutical services areavailable to provide residents with prescribed medications in accordance with applicable laws of Indiana.	05/29/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	sample of 2. (Resident #34) Findings included: A policy and procedure for "MEDICATION ERROR", with a revised date of February 2006, was provided by the Director of Health Services on 4/8/11 at 1:05 p.m. The policy included, but was not limited to: "The facility will follow the guidelines for medication assistance established by the State of Indiana...ALL medication errors that occur for residents receiving medication management services from the facility are required to be recorded. Medication management includes: medication set-up, reminders, assistance with self-administration (ex. cuing) and administration by licensed staff. A medication error includes: wrong medication, wrong dosage, wrong time...wrong route, missed medication. The medication Error Report form must be completed each time an error is discovered. ALL medications involved in the incident must be listed on the second page of the report form...All other medication errors shall be recorded on the Medication Error report and kept on file in the Administrator's office for ISDOH review...." 1. Resident #C's record was reviewed on 4/6/11 at 11:25 a.m. The record indicated		Residents are provided with automatic refill cycles of prescribed medicationsin that multiple doses of routinely given medications are available. Corrective action for residents affected:Resident C, D and 34: Unable tocorrect the clinical record. Measures to ensure practice does not recur:Medication error reports are accurately documented and kepton file for review by ISDOH.This corrective action will be monitored by:The Director of Health Servicesor designee will be responsible for completing a clinical record audit of all residents weekly for 4 weeks, then every other week for8 weeks, then monthly for 3 months. Results will be reported to the QA team for review and further corrective actions as deemed necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident #C was admitted with diagnoses that included, but were not limited to, pacemaker, osteoarthritis, high blood fats, constipation, congestive heart failure, hypothyroidism, high blood pressure, chronic obstructive pulmonary disease (COPD), and back pain. MARs for February 2011 indicated the following medications had been initialed and the initials circled which indicated the medication had not been given: - February 9 and 28: Crestor, with the explanation "med [not] available" on the back of the MAR. - February 21 and 22 at 8:00 a.m. and February 21 at 4:00 p.m.: Furosemide, with the explanation "[not] available" on the back of the MAR. MARs for March 2011 indicated the following medication had been initialed as not given: - February 2, 3, 6, and 10: Crestor, with the explanation on the back of the MAR of "med [not] available". 2. Resident #D's record was reviewed on 4/5/11 at 2:05 p.m. The record indicated Resident #D was admitted with diagnoses that included, but were not limited to, peripheral vascular disease, depression, Alzheimer's disease, high blood pressure,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	renal disease, vitamin B-12 deficiency, constipation, and insomnia. MARs for February 2011 indicated the following medications had been initialed and the initials circled which indicated the medication had not been given: - February 16: Temazepam, with the explanation on the back of the MAR "[not] available". - February 20: Aspirin, with the explanation on the back of the MAR "[not] available". - February 17 and 21: Vitamin B-12, with the explanation on the back of the MAR "[not] available". - February 19, 20, 21: Paroxetine, with the explanation on the back of the MAR "[not] available". 3. Resident #34's record was reviewed on 4/7/11 at 10:45 a.m. The record indicated Resident #34 was admitted with diagnoses that included, but were not limited to, high blood pressure, gastroesophageal reflux disease, high cholesterol, pulmonary high blood pressure, depression, arthritis, macular degeneration, angina, and atrial fibrillation. MARs for February 2011 indicated the following medications had been initialed			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and the initials circled which indicated the medication had not been given: - March 24, 25, and 28: Alprazolam 0.5 mg, with the explanation on the back of the MAR - "[not] available" for the 3/24 dose. The 3/25 dose had no explanation why it had not been given. During an interview on 4/8/11 at 11:54 a.m., the Director of Health Services indicated the facility's protocol was to circle the med not given, write the reason on the back of the MAR, try to get the med in, and they make sure it (the medication) was ordered. This State Residential Rule finding relates to complaints IN00087366 and IN00087411.			
R0298	(2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	sixty (60) days. Based on record review and interview, the facility failed to ensure drug regimen reviews were conducted every 60 days for 1 of 7 sampled residents. (Resident #38) Findings include: Resident #38's clinical record was reviewed on 4-4-11 at 11:45 a.m. Review of the "Consultant Pharmacist Drug Regimen Review" form indicated no drug review was conducted between the dates of 8-3-10 and 12-8-10, indicating a period of 127 days between drug reviews. In interview with the Director of Nursing (DON) on 4-6-11 at 3:14 p.m., she indicated she could not find any other drug review for Resident #38 for the time frame of 8-3-10 until 12-8-10.	R0298	If the facility controls, handles, and administers medications for a resident, the facility shall arrange services with a compliance packaging pharmacy to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Residents are provided with automatic refill cycles of prescribed medications in that multiple doses of routinely given medications are available. **Corrective action for residents affected:** Resident C, D and 34: Unable to correct the clinical record. **Measures to ensure practice does not recur:** Medication error reports are accurately documented and kept on file for review by ISDOH. **This corrective action will be monitored by:** The Director of Health Services or designee will be responsible for completing a clinical record audit of all residents weekly for 4 weeks, then every other week for 8 weeks, then monthly for 3 months. Results will be reported to the QA team for review and further corrective actions as deemed necessary.	05/29/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0300	(4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation, the facility failed to ensure proper labeling of 3 over the counter (OTC) medications found in 1 of 2 supplemental sampled residents reviewed for pharmaceutical compliance. (Resident #4) Findings include: Resident #4's room was toured on 4-6-11 at 2:45 p.m. with the Maintenance Director and (Facility) Director during the environmental tour. During this tour, 3 bottles of over-the counter medications, labeled as Tylenol, Pepto Bismol and MegaRed, were observed on the kitchen counter near the kitchen sink. These bottles were observed to have only the manufacturer's label on them.	R0300	Over-the-counter medications,prescription drugs, andbiologicals used in the facility arelabeled in accordance with currently accepted professional principles including appropriate accessory and cautionary instructions and expiration date. Corrective action for residents affected:Res 4 - unable to correct theclinical record citation. Medications, including, over-the-counter medications are labeled, stored, administered and documented in accordance with MD orders.Other residents having the potential to be affected and corrective actions:All residents with over-the-counter medications have the potential to be affected by this deficient practice. Medications, including, over-the-counter medications are labeled, stored,administered and documented in accordance with MD orders. This corrective action will be monitored by:The Director of Health Servicesor designee will be responsible for completing OTC Medication audits of all residents weekly for4 weeks, then every other week for 8 weeks, then monthly for 3 months.	05/29/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Results will be reported to the QA team for review and further corrective actions as deemed necessary.	
R0302	(6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on observation, the facility failed to ensure proper labeling of 3 over the counter (OTC) medications found in 1 of 2 supplemental sampled residents reviewed for pharmaceutical compliance. (Resident #4) Findings include: Resident #4's room was toured on 4-6-11 at 2:45 p.m. with the Maintenance Director and Site Director during the environmental tour. During this tour, 3 bottles of over-the counter medications, labeled as Tylenol, Pepto Bismol and MegaRed, were observed on the kitchen counter near the kitchen sink. These bottles were observed to have only the manufacturer's label on them.	R0302	Over-the-counter medications areidentified with the resident name, physician name, expiration date, name of drug and strength. Corrective action for residents affected:Resident #4: Unable to correct theclinical record. OTC medications have proper labeling.Other residents having the potential to be affected and corrective actions:Residents with OTC medicationhave the potential to be affected. OTC medications have proper labeling.Measures to ensure practice does not recur:New policies and procedures relative to medication administration, documentation of same, and monitoring for side effects have been implemented. This corrective action will be monitored by:The facility shall ensure properlabeling of OTC medications for all residents.	05/29/2011
R0304	(e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit.			
	Based on observation, interview and record review, the facility failed to ensure Schedule II drugs were double locked at all times and/or supervised by authorized personnel . This deficient practice has the potential to adversely affect all resident who have current Schedule II medications. Findings include: On 4-7-11 at 4:27 p.m., an unattended 2-tiered medication cart was observed to be in the first floor hallway, near room # 111. On the bottom shelf of the cart was a large box that resembled a fishing tackle box with a singular lock. A box similar to this had been previously identified by the Director of Nursing (DON) as the currently used box in which narcotics or Schedule II medications are stored and locked and then locked inside a cabinet in the locked Nursing Office. This cart and box were unattended by any facility staff for two minutes, until 4:29 p.m. In interview with LPN #3 on 4-7-11 at 5:02 p.m., she indicated her normal routine when passing medications is to take the locked narcotic box (tackle box)	R0304	Medicine or treatment cabinets orrooms are appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility are kept in individual containers under double lock and stored in a substantially constructed box, cabinet, ormobile drug storage unit. Corrective action for residents affected:The facility shall ensure ScheduleII drugs are double locked at all times and/or supervised by authorized personnel.Other residents having the potential to be affected and corrective actions:This deficient practice has thepotential to adversely affect all resident who have current Schedule II medications.	05/29/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with her into each room. She indicated that she "just forgot" to take it with her when the observation was made earlier the same afternoon. On 4-8-11 at 4:40 p.m., the DON provided documentation which indicated 11 residents with a total of 16 Schedule II medications and 494 doses of medication were currently contained in the locked narcotic box.			
R0349	(a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure complete and accurate clinical record documentation in that nurse's notes entries did not include times and/or signature of the staff members that made the entry, and documentation for hourly checks and blood sugar testing was not in the clinical record. This affected 2 of 7 residents in a sample of 7. (Resident #C and Resident #38) Findings include:	R0349	The facility maintains clinicalrecords that are complete, accurately documented, readily accessible, and systematically organized.Corrective action for residents affected:Res C: unable to correct the clinical record citation. Accurateclinical documentation within the nursing notes includes times and/or signature of the staffmember that made the entry.Medications are administered and documented in accordance with MD orders.Res 38: unable to correct the clinical record citation. Accurate clinical documentation of hourly checks	05/29/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1. Resident #C's record was reviewed on 4/6/11 at 11:25 a.m. The record indicated Resident #C was admitted with diagnoses that included, but were not limited to, congestive heart failure, high blood pressure, and osteoarthritis. The following nurse's notes failed to include the time the entry was made: 2/28/11 (2 entries), 3/1/11, 3/3/11, 3/6/11, 3/10/11 (2 entries), 3/13/11, 3/14/11 (2 entries), and 3/15/11. A nurse's note entry dated 3/9/11 at 1445 (2:45 p.m.) failed to include any documentation and had two blank lines after the date and time. An entry dated 3/13/11 failed to include the signature and title of the person that made the entry. During an interview on 4/6/11 at 5:02 p.m., the Director of Health Services indicated nurse's notes entries are supposed to be signed and have dates and times. 2. Resident #38's clinical record was reviewed 4-4-11 at 11:45 a.m. Her diagnoses included, but were not limited to uncontrolled diabetes mellitus type 2,		and blood sugar testing within the clinical record are completed and service plan updated. Medications are administered and documented in accordance with MD orders. Other residents having the potential to be affected and corrective actions:All residents have the potential to be affected by this deficient practice. Clinical and MedicationAdministration Records for April have been reviewed, and documentation is complete and accurate.Measures to ensure practice does not recur:New policies and proceduresrelative to medication management, clinical records, and service planning have been implemented. All qualified health services staff has been in-serviced on the procedures.This corrective action will be monitored by:The Director of Health Services or designee will be responsiblefor completing audits of clinical and medication administration records for residents receivingmedication administration services weekly for 4 weeks, then every other week for 8 weeks, then monthly for 3 months.Results will be reported to the QA team for review and further corrective actions as deemed necessary. The facility maintains clinicalrecords that are complete, accurately documented, readily accessible, and systematically organized.Corrective action for	05/29/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	congestive heart failure and coronary artery disease. Documentation of her blood glucose (blood sugar) results were documented on a form entitled, "Blood Sugar Test," as well as located on the Medication Administration Record (MAR) and within the nursing progress notes. The ability to easily identify trends in this resident's blood sugar (BS) fluctuations was difficult as the "Blood Sugar Test" log was not used routinely to record all readings. For example, between the time period 2-21-11 until 3-4-11, there were no dates or BS readings recorded on the log. The MAR indicated on 3-9-11 that the BS readings were physician-ordered to be increased from twice weekly to twice daily at 8:00 a.m. and 4:00 p.m. The MAR indicated that when the BS readings were at twice weekly, the actual numerical readings were recorded on the MAR, as well as the "Blood Sugar Test" log. When the BS readings were increased to twice daily, the staff responsible for this initialed that the test had been conducted, not the results on the MAR, with the exception of 6 occasions, but did not indicate what time the results were obtained. On the 6 occasions that the results were recorded on the twice daily section of the MAR, it only indicated the testing occurred one time each on those		residents affected:Res C: unable to correct the clinical record citation. Accurateclinical documentation within the nursing notes includes times and/or signature of the staffmember that made the entry.Medications are administered and documented in accordance with MD orders.Res 38: unable to correct the clinical record citation. Accurate clinical documentation of hourly checks and blood sugar testing within the clinical record are completed and service plan updated. Medications are administered and documented in accordance with MD orders. Other residents having the potential to be affected and corrective actions:All residents have the potential to be affected by this deficient practice. Clinical and MedicationAdministration Records for April have been reviewed, and documentation is complete and accurate.Measures to ensure practice does not recur:New policies and proceduresrelative to medication management, clinical records, and service planning have been implemented. All qualified health services staff has been in-serviced on the procedures.This corrective action will be monitored by:The Director of Health Services or designee will be responsiblefor completing audits of clinical and medication administration records for residents receivingmedication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dates. Additionally, for BS results recorded on the MAR and Blood Sugar Test log on 3-4-11 at 8:30 a.m., it indicated the BS was very low at 25, but nursing notes did not reflect what care, if any was provided. On 3-3-11, no BS was recorded on the MAR or Blood Sugar Test log, but nursing notes at 3-3-11 at 8:10 a.m. indicated, "...BS taken this AM (morning) due to found on floor in room very confused. Gave glucose and oj (orange juice.) Checked BS again at 8:45 a.m. up to 96 (within normal range.)" This entry did not indicate what the original BS reading was at 8:10 a.m. Review of the Blood Sugar Test Log, nursing notes and MAR entries for the dates 3-9-11 through 4-1-11 indicated numerical BS results were not documented for 3-14 morning, 3-18 only 1 time of 8:30 with no indication of a.m. or p.m., 3-19 neither morning or evening readings; 3-21 morning; 3-25 morning; 3-26 morning; 3-27 morning; 3-28 morning; 3-29 evening; 3-30 morning; and 4-1 evening. Review of Resident #38's most recent A1C test (test for degree of control of blood sugars over the last 3 months), dated 1-13-11 indicated it was grossly elevated at 12.2 (goal is to be less than 6.0). Documentation was located during the clinical record review of a form entitled,		administration services weekly for 4 weeks, then every other week for 8 weeks, then monthly for 3 months.Results will be reported to the QA team for review and further corrective actions as deemed necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"Safety Checks Form" which indicated on 3-6-11 routine hourly checks had been initiated on Resident #38. The forms indicated the frequency was changed the following day to every 2 hours and continued until 3-29-11. Review of nursing notes and the service plan did not indicate for what purpose the safety checks were initiated, but nursing notes indicated on 3-29-11 the safety checks were discontinued. In interview with the Director of Nursing on 4-6-11 at 3:14 p.m., she indicated the safety checks had been initiated due to issues related to hypoglycemia problems and the resident not routinely eating breakfast. She indicated, "Should have I put that information on the service plan?"			
R0406	(a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, record review, and interview, the facility failed to ensure staff were handling resident's medications in a safe and sanitary manner in that one staff member counted narcotics with her bare hands. This affected 1 of 7 residents observed during the medication pass. (Resident #34)	R0406	The facility has developed, andimplemented infection control policies and procedures to ensure controlled practices designed to provide a safe, sanitary, andcomfortable environment andhelp prevent the development and transmission of diseases and infection.Corrective action for residents affected:Res 34: Unable	05/29/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: A medication pass observation was done on 4/4/11 at 12:50 p.m. with LPN #4. During the observation, LPN #4 was observed as she completed a narcotic count of Vicodin 10/325 for Resident #34. The LPN cleaned her hands with a sanitizing lotion, placed a clean paper towel on top of the open medication administration book and poured the prescription bottle onto the paper towel. The LPN then counted the pills using her bare fingers by grouping the pills in piles of ten, then counting the piles. She re-counted the pills when the first count did not come out right, and touched all the pills with her bare fingers again. The LPN said she used the paper towel and her bare hands because she didn't have anything else to use. During an interview on 4/8/11 at 3:05 p.m., the Administrator indicated if they didn't use gloves to count the pills, they did wrong, it's just standard precautions. On 4/8/11 at 3:10 p.m., the Administrator provided a policy and procedure for "Medication Management - Medication Administration" with an effective date of 4/7/11. The policy included, but was not limited to: "...L. Apply professional		to correct the04/04/11 medication pass observation. Medications are administered using safe and sanitary practices.Other residents having the potential to be affected and corrective actions:All residents, to which, thefacility administers medications for, have the potential to be affected by this deficient practice. Policies and procedures relativeto Medication Administration andInfection Control are in place to ensure professional standards of medication administration. On April 27, 2011 all staff qualified to administer medications were inserviced on Infection Control and Medication Management. Measures to ensure practice does not recur:Policies and procedures relativeto Medication Administration and Infection Control are in place to ensure professional standards of medication administration. On April 27, 2011 all staff qualifiedto administer medications wereinserviced on Infection Control and Medication Administration. This corrective action will be monitored by:The Director of Health Servicesor designee will be responsible for completing an observational medication pass audit on all staff qualified to administer medications weekly for 4 weeks, then every other week for 8 weeks, then monthly for 3 months. Results will be reported to the QA team for review and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	standards of practice as defined in facility policy, Standard Precautions, and manufacturer's instructions for the proper method of administering different medications forms and routes...."		further corrective actions as deemed necessary.	